State of Tennessee Department of Children's Services

Administrative Policies and Procedures: 20.24

Subject: Informed Consent

Supersedes: DCS 20.24, 02/01/00

Local Policy: No
Local Procedures: No
Training Required: No
Applicable Practice Model Standard(s): Yes

Approved by: Viola P. Miller

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Application

To All Department of Children's Services Employees

Authority:

TCA 37-5-106, TCA 33-8-202, TCA 37-10-303-304, TCA 63-6-220, TCA 63-6-222-223, TCA 68-10-104(c), TCA 68-34-107, and *Cardwell v. Bechtol* (724 S.W. 2d 739).

Policy

In order for children in custody to receive appropriate medical and behavioral/mental health services, DCS shall facilitate the informed consent process by either obtaining or providing the consent as appropriate.

Principles

A. Informed consent

1. Informed consent is based on the fundamental principle that every person has the right to control his/her own bodily integrity.

2. Every patient has the right to receive information regarding prescribed tests or treatments, including risks and benefits of taking the tests or treatments and risks/benefits of not taking the tests or treatments.

3. The patient has a right to receive sufficient information to enable the patient to make an informed decision about

whether to consent to or refuse the tests or treatments.

4. The practitioner should provide a verbal and/or written explanation about the prescribed treatment or test, explained in a way the patient fully understands, which generally includes the following:

   a) Diagnosis for which the treatment/medication is prescribed;

   b) Nature of the medication, treatment, test, or procedure;

   c) Name of the medication, including both generic and brand names;

   d) Dosage and frequency of medication;

   e) Expected benefits;

   f) Possible risks and side effects;

   g) Availability of alternatives; and

   h) Prognosis without proposed intervention.

5. Informed consent is the consent to treatment given after the patient, legal custodian, and/or legal guardian has received sufficient information about the risks and benefits of taking and not taking a prescribed or recommended treatment. Depending upon the setting and the provider, the patient/guardian may be asked to sign a form documenting their consent to or refusal of treatment.

B. Legal Rights

1. Unless or until parental rights are terminated, a child's parent has the legal right and responsibility to consent to medical treatment for his/her child, except for the situations listed below in ***Section C*** and in ***Section E6***.

2. At the Initial Child and Family Team Meeting, (see DCS Policy *31.8, Initial Child and Family Team Meeting*), parents should be informed of this right and responsibility, as well as the expectation that they will participate in the medical and treatment decision making for their child.

3. DCS is authorized to consent to ordinary and/or necessary medical care and/or treatment by virtue of the court's order granting DCS legal custody. As the legal custodian, DCS may provide consent without parental permission if absolutely necessary. However, best practice is to involve

the parent(s) in the child's treatment and to facilitate their parental role in giving informed consent when that can be done without harm to the child. Every effort will be made by the case manager to contact the parent or legal guardian and discuss the medical care and/or recommended treatment.

4. The parent(s) shall be informed at the Initial Child and Family Team Meeting that if they are unavailable to consent to medical treatment for their child, then DCS will do so under its authority as the legal custodian. The parent(s) shall also be informed that DCS honors their role as the parent and will make every effort to involve them in the decision making process about the care of their child. In cases in which the parents refuse to consent to medical treatment or procedures, DCS will consult with the prescribing health care provider to determine if:

    a) The treatment or procedure is medically necessary,

    b) If the child may be harmed if he/she does not receive the treatment or procedure, and

    c) If there are any less invasive alternative treatments available.

5. If after consulting with the provider, DCS determines that the treatment is necessary to protect the child from harm and having the treatment is in the best interest of the child, then DCS will give consent for the treatment. (For example, if not having the treatment or medication will potentially contribute to the child's condition deteriorating, his/her placement being disrupted, or interfering with permanency or reunification, then DCS will consent to the treatment.)

6. Tennessee law presumes that children 14 years of age and older have the maturity to consent to medical treatment, but it has to be determined on a case-by-case basis by the prescribing health care provider. Because of this presumption, some providers may require both parental consent and the consent of an older minor, subject to the special additional requirements for children 16 years and older set forth in ***Section B7***.

    a) Since some 14 year old and older children may be mature enough to make informed consent decisions, such children may refuse treatment or medication.

    b) Any child refusing treatment should be appropriately counseled regarding the impact of such refusal. Both

counseling efforts and refusal must be documented in the case recordings and medical module in TN Kids, and in the child's case file record using *form CS-0093, Release From Medical Responsibility.*

c) If a child refuses treatment or medication, the case manager shall consult with the prescribing provider for a professional determination as to whether:

- The provider deems the child mature enough to understand the consequences of his/her decision, and
- Whether going without the treatment or medication will result in harm to the child.

a) If the provider determines that:

- The child is mature enough to make an informed decision,
- That the child will be harmed by not having the treatment or medication,
- That the treatment is medically necessary, and
- There are no other available alternatives,

The DCS case manager shall consult with local DCS legal counsel to determine if judicial intervention is needed.

d) A mature 14 year old (or older) child's decision to refuse medical treatment or tests shall not be overridden by DCS or a parent giving consent for the refused treatment, if the provider has determined the child is mature enough to make the decision.

e) In the situations described in ***6 (c)*** and ***(d)*** above, the DCS case manager will consult with local DCS legal counsel to determine if judicial intervention is needed. Local DCS legal counsel will determine whether a motion should be filed with the juvenile court requesting that an attorney ad litem, a conservator, and/or a guardian ad litem (GAL) be appointed for the youth.

f) If the provider determines that the 14 year old or older child does **not** have the capacity to make an informed decision, then parental consent should be obtained when the child refuses treatment or medication. If the

parent is unavailable or refuses to consent, DCS will consult with the prescribing health care provider to determine:

- ♦ If the treatment or procedure is medically necessary,
- ♦ If the child may be harmed if he/she does not receive the treatment or procedure, and
- ♦ If there are any less invasive alternative treatments available.

g) If after consulting with the provider, DCS determines that the treatment is necessary to protect the child from harm and is in the best interest of the child, then DCS will give consent for the treatment. The DCS case manager also will consult with the local DCS attorney to help determine appropriate action.

7. **Older children have special rights with regard to mental health services.** Children with serious emotional disturbance or mental illness, who are 16 years old or older, have the same rights as adults with respect to outpatient and inpatient mental health treatment, medication decisions, confidential information, and participation in conflict resolution procedures. (*TCA 33-8-202*)

8. These older children can sign their own consents for medication related to the treatment of their mental health condition. When these children sign consent, a second signature from the parent or health unit nurse is not needed. If the child's treatment needs conflict with the child's decision, the case manager should consult with the prescribing health care provider to determine:

- ♦ If the treatment or procedure is medically necessary,
- ♦ If the child may be harmed if he/she does not receive the treatment or procedure, and
- ♦ If there are any less invasive alternative treatments available.

9. If after consulting with the provider, DCS determines that the treatment is necessary to protect the child from harm and having the treatment is in the best interest of the child, then the case manager should contact the local DCS attorney for judicial intervention.

10. Local DCS legal counsel will determine if an attorney ad litem, a conservator, and/or a guardian ad litem (GAL) should be appointed for the child and will file the appropriate motion with the juvenile court.

(Note that this situation differs from the refusal of a 14 year old, as described in section 6 above. *TCA 33-8-202* explicitly states that 16 year olds in this situation have the same rights as adults.**)**

C. Exceptions to the requirement for parental consent to treat minors

1. Children 16 years of age and older can provide consent for psychotropic medication and mental health treatment (*TCA 33-8-202*). Parental consent or the consent of the DCS health unit nurse is not needed if a 16-year-old child (or older) provides consent.

2. Treatment of juvenile drug abusers does not require prior parental consent. A physician may use his/her own discretion in determining whether to notify the juvenile's parents of such treatment. (*TCA 63-6-220*)

3. Any person licensed to practice medicine may provide prenatal care to a minor without the knowledge or consent of the parents or legal guardian of the minor. (*TCA 63-6-223*)

4. Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, is a parent, is married, has been referred for such service by another physician, a clergy member, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of the state, or who requests and is in need of birth control procedures, supplies, or information. (*TCA 68-34-107*)

5. Any state, district, county or municipal health officer or any physician may examine, diagnose, and treat minors infected with sexually transmitted diseases without the knowledge or consent of the parent(s) of the minor. (*TCA 63-10-104c*)

6. Any licensed physician may perform emergency medical or surgical treatment on a minor without parental consent or a court order, if the physician has a good faith belief that delaying the care would result in serious threat to the life of the minor or a serious worsening of the minor's medical condition, and that the emergency treatment is necessary to save the minor's life or prevent further deterioration. A reasonable effort must first be made to notify the minor's parents or guardian. (*TCA 63-6-222*)

7. A minor may petition the juvenile court for a waiver of the parental consent requirement for performance of an abortion on a minor. The court may waive the parental consent requirement if the court finds that the minor is mature enough and well informed enough to make the abortion decision on her own, OR that performance of the abortion would be in the minor's best interest. (*TCA 37-10-303-304*)

   Nurse practitioners or physicians' assistants who are working under the supervision of a licensed physician may provide some services.

D. Liability issues

1. When providing informed consent, the DCS staff/representative, foster parent, or contract agency caseworker is giving informed permission for treatment to be provided to a child. The DCS staff/representative is in no way prescribing such services, but rather, permitting prescribed treatment to be provided.

2. In deciding to give informed consent, DCS staff/ representatives should ask questions as appropriate or needed, and should seek assistance from the DCS regional health nurse, psychologist, supervisory staff, or the local DCS attorney if they have further questions.

3. Providing consent/permission is an essential part of the duties of a legal custodian and DCS staff members are immune from liability while performing these duties within the scope of their employment.

E. Consent for routine medical care

1. DCS staff having the first contact with the family will require the child (if 14 years old or older) and the parent(s) to sign form CS-0206, *Informed Consent to Routine Health Services for Minors*, at the time the child enters state custody, or no later than the Initial Child and Family Team meeting. This form allows for the child to receive general medical treatment and EPSDT screening and follow-up, but does not preclude the need for separate informed consent for further treatment and psychotropic medication.

2. The case manager[1], the foster parent, and the contract agency caseworker are authorized by DCS to sign consent

[1] This includes the case manager's supervisor(s) or Regional Administrator's designee(s).

for routine medical care. They may sign consent if the child's parent is unavailable or unwilling to sign consent. Before DCS signs consent, every effort will be made to inform the parent and provide them the opportunity to give consent. Case aides may not sign consent. The parent should be notified as soon as possible if someone else signed the consent because the parent was unavailable.

3. Designated community residential program staff shall be authorized by DCS to sign consent for all routine matters for children in DCS Group Homes if a child's parents are unavailable or unwilling to sign consent. The parent should be notified as soon as possible if someone else signed the consent because the parent was unavailable. (See glossary section, definition of "*Designee").*

4. Designated Youth Developmental Center staff (Superintendent or designee) shall be authorized by DCS to sign consent for all routine matters for children in DCS YDCs if a child's parents are unavailable or unwilling to sign consent. The parent should be notified as soon as possible if someone else signed the consent because the parent was unavailable. (See glossary section, definition of "*Designee").*

5. If the parent refuses to give consent to the medical care, DCS staff shall consult with the prescribing provider for a determination as to whether the child will be harmed if he/she does not receive the care. If the provider determines that the child will be harmed without the medical care then DCS will consent to the medical care or treatment.

6. If the termination of parental rights is in process, or the permanency goal is no longer reunification, the case manager should consult with the local DCS attorney to determine whether they should seek the parent's consent for medical treatment of the child.

F. Consent for emergency medical treatment

1. The DCS case manager, the contract agency caseworker, and the foster parent may all give consent at the time emergency medical care is needed. If the foster parent or the contract agency caseworker signs the consent, they will notify the DCS case manager immediately. The case manager shall contact the child's parent(s) as soon as possible to inform them of the emergency room procedures or emergency medical care given and the need for any follow up care.

2. When a child in a DCS Group Home requires emergency medical treatment, a designated community residential program (CRP) staff member will accompany the child and will give consent when required for all procedures performed. The CRP staff will contact the parent(s) as soon as possible to inform them of the emergency room procedures or emergency medical care given and the need for any follow up care. The CRP staff shall also notify the DCS home county case manager of the emergency room visit, treatment provided, and follow-up care needed.

3. When a child in a YDC requires emergency medical treatment, a designated YDC staff member will accompany the child and will give consent when required for all procedures performed. The YDC staff will contact the parents as soon as possible to inform them of the emergency room procedures or the emergency medical care given and the need for any follow up care. The YDC staff shall also notify the DCS home county case manager of the emergency room visit, treatment provided, and follow-up needed.

G. Consent for surgical procedures

1. **<u>Foster Care and Contract Agencies</u>**: When a surgical procedure is necessary for a child in foster care or a contract agency placement, the DCS case manager will notify the parent(s) and the Health Unit Nurse. The case manager will arrange for the parent(s) to attend the presurgical appointment with the physician or dentist and accompany the child to the hospital. The parent(s) will make the decision to consent to or refuse the surgery. If consent is given, the parent(s) will sign the Surgical Consent form provided by the physician, dentist, or the hospital staff. If the parent(s) cannot or will not be available to determine consent, the Health Unit Nurse will make the decision to consent to or refuse the treatment. A copy of the consent will be placed in the child's case record/Master file, and the surgical procedure including its outcome will be documented in TNKids by the case manager. (See procedures outlined in section I).

2. **<u>DCS Group Homes and YDCs</u>**: When a surgical procedure is necessary for a child in a DCS Group Home or YDC, a designated CRP or YDC staff member will contact the parent(s) to attend the presurgical appointment with the physician or dentist and accompany the youth to the hospital. The parent(s) will make the decision to consent to

or refuse the surgical procedure. If consent is given, the parent(s) will sign the Surgical Consent Form provided by the physician, dentist, or the hospital staff. If the parent(s) cannot or will not be available to determine consent, the CRP supervisor/designee or YDC superintendent/designee will make the decision to consent to or refuse the treatment. A copy of the consent will be placed in the child's case record/master file, and the surgical procedure including its outcome will be documented in TNKids by the case manager.

3. When a child is scheduled for a surgical procedure, the parent, foster parent, CRP or YDC staff member, DCS case manager, and/or contract agency case manager will remain at the hospital with the child through the hospital admission process, when the child is taken to surgery, during surgery and recovery, when the child returns from surgery and when the child is discharged from the hospital.

4. If a parent refuses to consent to a surgical or other invasive procedure for their child, the DCS case manager shall consult with the prescribing physician or dentist to determine:

   - If the procedure is medically necessary,
   - If the child may be harmed if he/she does not receive the procedure, and
   - If there are any less invasive alternative treatments available.

5. If after consulting with the provider, DCS determines that the surgery/procedure is necessary to protect the child from harm and is in the best interest of the child, then DCS will give consent for the treatment.

6. If the physician, dentist, or hospital does not provide a surgical consent form, DCS form *CS-0631*, *Informed Consent for Surgical Procedure* may be used to document the consent.

H. Consent for psychotropic medications

1. When psychotropic medication is prescribed for a child in foster care, a contract agency placement, or a DCS Group Home, the parent(s) will be contacted to determine consent or refusal of medication for children less than 16 years of age, subject to the provisions regarding mature minors set forth in section *B6*. If the parent is unavailable to sign consent, the regional health advocacy nurse will be

contacted to sign consent for psychotropic medications for children in foster care, contract agencies, and DCS Group Homes, if the child is under the age of 16. (*See procedures outlined in section I*.)

2. When psychotropic medication is prescribed for a child in a YDC, the parent will be contacted by designated YDC staff to determine consent or refusal of medication for children less than 16 years of age, subject to the provisions regarding mature minors set forth in section *B6*. If the parent is not available to give consent, the YDC superintendent/designee will be contacted to give consent to the medication, if the child is under the age of 16. The YDC superintendent/designee also will provide notification to the parent of the medication, to include a fact sheet regarding the medication, and to the home county case manager.

3. If the parent refuses to give consent for psychotropic medication for a child under the 16 years of age, DCS shall consult with the prescribing provider to determine:

   - If the medication is medically necessary,
   - If the child may be harmed if he/she does not take the medication, and
   - If there are any less invasive or alternative treatments available.

   If after consulting with the provider, DCS determines that the medication is necessary to protect the child from harm and is in the best interest of the child, then DCS will give consent for the treatment.

I. Procedure for notification of parents and obtaining psychotropic medication informed consent from the regional health unit nurse

1. This section applies to children in foster care, residential contracted agencies, and DCS Group Homes.

2. Initial Child and Family Team Meetings and Permanency Plan Staffings will include a discussion of the possibility of mental health evaluations and psychotropic medications. Case managers will advise parents that their attendance at appointments and involvement in their child's care, including informed consent, is expected and welcomed. The statute regarding children 16 years and older signing their own consents will be reviewed at these meetings, if applicable. These discussions will be documented in TNKids case recordings.

3. Case managers will notify parents of psychiatric appointments by direct contact, phone, or mail and request their attendance. In the event the parent cannot attend the appointment, the case manager will request that he/she be available by phone for consultation at the time of the appointment. The case manager will relay this information to the psychiatrist. Efforts to involve the parent, including the parent's actual involvement or reasons why the parent could not or should not be involved, will be documented in TNKids case recordings.

4. When a psychotropic medication is prescribed, form *CS-0627, Informed Consent for Psychotropic Medication* will be completed by the prescribing healthcare provider. The consent will be signed by the child, if age 16 years or over, or by the parent. Efforts to reach the parent should be documented on the form in the appropriate space. If the parent is not available within 24 hours, form *CS-0627, Informed Consent for Psychotropic Medication* will be forwarded to the Regional Health Advocacy Nurse for signature. The nurse will sign and fax the consent to the appropriate party so the child can begin the medication. If the medication is not an urgent administration as deemed by the prescribing provider or the Health Unit Nurse, the case manager may take an additional 24 to 48 hours to notify the parent and to obtain consent. If the child is in a level IV facility and the parent cannot be located within 4 hours, or less if late in the business day, the consent should be signed by the Health Unit Nurse.

5. Once the Health Unit Nurse has signed the consent, he/she will send a memo to the case manager, together with a fact sheet describing the medication, for the case manager to forward to the parent to inform him/her of the medication and obtain their assent/agreement at the earliest possible opportunity. If the parent cannot be located for children under 16 years of age, the case manager will document reasonable efforts to notify them in the TNKids case recordings. In the case of a child age 16 years or older, the parent will be notified of the medication only with the written consent of the child. If the child does not want the parent informed of the medication, this confidentiality will be documented on the consent form.

6. If the parent has questions about the medication, the Health Unit Nurse or Psychologist will answer all questions to the best of their ability. If concerns go beyond this, the Nurse will arrange for the parent to discuss his/her concerns with

the prescribing physician.

7. If the parent refuses to consent for the prescribed medication for a child under age 16 years, and the Health Unit Nurse, in conjunction with the prescribing provider, feels the medication is needed and the child's treatment progress will be hindered by not receiving the medication, the nurse will give consent.

8. If a child age 16 or older refuses to consent to psychotropic medication, his/her refusal shall not be overridden by either the parent's consent or the consent of DCS. If the provider believes the refusal will result in harm to the child, or have detrimental health effects, the provider will notify the DCS case manager and the Health Unit Nurse. They, in turn, will consult with DCS legal counsel to determine if judicial intervention is needed. Local DCS legal counsel will determine if a motion should be filed with the juvenile court requesting an attorney ad litem, a conservator, and/or a guardian ad litem to be appointed for the child.

9. In some instances, the case manager will only be able to obtain a verbal consent for medication. The case manager will document on the DCS consent form that the consent was given verbally and note by whom it was given (e.g., parent, health unit nurse). A second person should witness the verbal consent, whenever possible, and document that on the consent form. The consent form should then be sent to the parents and/or health unit nurse for a signature.

10. Informed consent is given for a specific child to take a specific psychotropic medication(s). Dosage changes within standard titration limits (average dose ranges) and discontinuation of medication do not require new consents. If a medication is stopped for more than 14 days, it cannot be restarted unless a new consent is obtained.

11. Informed Consent for Psychotropic Medication will travel with the child. If a child's placement is changed, the consent forms for current medications will accompany the child to the new care provider.

12. Some medications, such as anti-seizure drugs, can be used for medical or psychiatric conditions. When prescribed for a medical condition, these medications do not require written informed consent from the health unit nurse. Only medications prescribed for a mental health diagnosis or used as a psychotropic medication require this informed consent.

13. If a child remains on the same medication at the same dosage for a year, renewal consent should be obtained so all parties are aware of the continued prescribed medication.

14. If a child is in a level IV placement and requires urgent consent for the administration of psychotropic medications outside of regular DCS business hours, the provider can contact the DCS on-call person, who will then contact the Health Unit Nurse. Either the nurse or the nurse's designee will determine whether to give or refuse consent for the administration of the medication. The parent will be notified on the next business day according to #4 above.

15. Health Unit nurses will not sign consent for medications that have already been given to youth. When a health unit nurse receives a request for a psychotropic medication that a child has been taking, the nurse will evaluate the consent for current use and sign with the current review date if appropriate. The nurse will not backdate consent forms (for any reason), nor will the nurse automatically sign consent for a medication that a child has been taking (without previous consent). The nurse will contact the prescribing provider (and the case manager) to determine the next steps in medication management. DCS Quality Assurance will be notified about the providers who request consent after medications have been given, and about providers who are discovered to have never requested consent from the parents or the Health Unit nurses.

J. Emergency administration of psychotropic medications

1. If an emergency administration of a psychotropic medication is deemed necessary for the protection of a child in state custody, the medication should be administered per physician order. Consent is not needed prior to the emergency administration, but the DCS case manager, parent, and Health Unit Nurse are to be notified at the earliest possible opportunity (within 24 hours). For the purposes of administration of medication, emergency means:

   a) An immediate threat of serious physical harm to the service recipient or to others caused by the violent behavior of the service recipient; or

   b) An immediate threat to the service recipient of deteriorating physical well-being with risk to life or long term health caused by the effects of mental illness or serious emotional disturbance; or

c) The need to prevent substantial deterioration of the service recipient's mental health or to prevent physical harm to the service recipient or to others, and the need is greater than any potential harm to the service recipient; or

2. An immediate threat to the service recipient of deteriorating physical well-being with risk to life or long term health caused by the effects of a physical illness or condition.

(From Tennessee Dept. of Mental Health and Developmental Disabilities, Division of Mental Health Services, Chapter 0940-3-9 Treatment Review Committee)

K. Tracking children on psychotropic medications

1. DCS requires case managers and agency personnel to notify the Health Unit Nurse of all psychotropic medications prescribed, all dosage changes, and discontinuation of medication for all children in custody. A notification to the Health Unit Nurse is necessary for a psychotropic medication for which a child age 16 years and older or a parent has signed. In these situations consent is not needed from the Health Unit Nurse, but the nurse must be notified of the situation so that he/she is able to track the medications.

2. DCS is responsible for tracking and monitoring all children in custody on psychotropic medications. The health unit nurse will maintain a file on each child, while in custody, with all relevant information about prescribed medication. Records of all prescribed medication and consent forms will be placed in the child's case file and the health unit nurse (or administrative support) will enter the information into the psychotropic medication log.

Forms

CS-0093	Release From Medical Responsibility
CS-0206	Informed Consent For Routine Health Care Services for Minors
CS-0627	Informed Consent For Psychotropic Medication
CS-0631	Informed Consent For Surgical Procedure

Collateral Documents

None

Standards

ACA 3-JCRF-4C-25

ACA 3-JTS-4C-44

DCS Practice Model Standard – 7-100A

DCS Practice Model Standard – 7-114A

DCS Practice Model Standard – 7-120C

DCS Practice Model Standard – 7-208B

DCS Practice Model Standard – 8-304

DCS Practice Model Standard – 8-306

Glossary

Term	***Definition***
Attorney ad Litem	An attorney appointed by a court to represent the wishes and interests of an individual during court proceedings for determining the need for a conservator.
Conservator	Someone appointed by a court, to whom an individual's rights have been transferred. For example, the right to make decisions about treatment or medical care may be transferred from the individual to the conservator, giving the conservator the authority to consent or refuse medical treatment on behalf of the individual.
Contract Agency Case Worker	A staff person of a DCS contract agency providing services for DCS state custody children and youth. This person works directly with the youth in custody.
Case Aide	An individual who was solely hired to assist case managers in their routine job performances.
Parent(s)	Refers to biological parent, adoptive parent, or legal guardian.

Designee The employees listed below shall be the designees of the Commissioner for consent of routine and non-routine health services of minors in physical custody:

- For foster homes or contract agencies: the team leaders, residential case managers, case managers, regional health advocacy nurses or designees.
- For DCS community residential programs: the community residential facility supervisor or designee.
- For Peabody Residential Treatment Facility: the mental health/mental retardation standards coordinator or designee.
- For youth development centers: the youth development center superintendent or designee.

Emergent Emergency or urgent medical situation.

GAL Guardian ad litem; an attorney appointed by the juvenile court, pursuant to Title 37, to represent the best interests of the child in dependency and neglect proceedings. If the child's wishes conflict with what the GAL deems to be in the child's best interest, the GAL must ensure that the child also has an attorney appointed to represent the child's wishes..

A guardian ad litem may also be appointed pursuant to Title 34, by the probate or juvenile court, for proceedings to determine the need for a conservator.